NHS England

Congenital Heart Disease Provider Network Submissions: Report of the national commissioning panel

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- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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1 Introduction

The Board of NHS England set an ambition that CHD (Congenital Heart Disease) services should be commissioned against the new standards and service specifications from April 2016. NHS England commissioners asked hospitals, providing congenital heart disease services, to consider how best to ensure that all patients benefit from services that meet the new standards, and if they believe they cannot currently meet a standard, to propose the mitigation they would put in place. Provider trusts, working alongside commissioners, have been working together since 29 April 2015 to develop proposals for a network based delivery model. The purpose of the submissions was:

- **For providers**: to formally enable each provider/network to begin to assess themselves against the standards and service specifications, to understand their own strengths and limitations, and to create plans for achieving the standards including risk management in areas where the standards are not yet met.
- **For commissioners**: to allow NHS England to consider whether the emerging delivery models will, with the appropriate mitigations, produce an acceptable solution, in the best interests of patients. This will in turn enable NHS England to make a decision as to whether to continue with the current commissioning approach.

On 9 October 2015 submissions from networks were received by NHS England. In some cases these were for networks based on a single level 1 surgical centre, others described new multi-centre networks. Those proposals describing new ways of working were not as developed as those that are essentially similar to current arrangements. Although the new multi-centre networks will require more development we welcome the progress that has already been made in developing new collaborative approaches and working relationships in the interest of patients.

2 Panel findings

In the document 'Requirement for network submissions – overview' we indicated that a number of factors would be important in our evaluation of the proposals. The panel's findings have been organised (below) according to these factors.

2.1 Patient driven

The Clinical Reference Group (CRG) advised that all the proposals needed to demonstrate in real terms the patient benefits in the development of the Network. It was noted that some proposals had demonstrated strong patient involvement in preparing the Network proposals. This will need to occur across all the proposals as they are developed, as service users' views are vital to developing appropriate services.

2.2 Meeting the standards and specifications

Surgical caseloads, size of surgical teams and out-of-hours cover (and interventional caseloads, size of interventional teams and out-of-hours cover)

The panel considered it particularly important that networks were able to ensure that all surgeons were part of a team of at least four, with an on-call commitment no worse than 1:3 from April 2016 and 1:4 from April 2021, and that each undertakes at least 125 operations per year.

While the parallel requirements for interventional cardiology were also considered important, these would normally be met if the surgical requirements were met.

The CRG advised that the best way to meet these standards was for each centre to have a minimum of 500 cases. They also considered that in practice more than 500 cases would be needed because of the operational challenges of ensuring that all surgeons had 125 appropriate cases and that all patients received their care from an appropriate surgeon, if the numbers were only just 500. Taking this approach would ensure resilience, support patient outcomes and effective development of units and staff. Alternative approaches may still be permissible and would be considered on their own merits, however the CRG advised that peripatetic practice – occasional operating in other centres – could be associated with worse outcomes. The CRG did not advocate consultants operating in more than one centre, unless they were familiar with the hospital and spent a proportionate amount of time within that centre and were fully part of the team and able to participate in MDTs, audit and other improvement activities. Effective arrangements would need to be in place for perioperative care and the personal involvement of the surgeon concerned was considered the ideal. Surgeons must not be on-call for more than one centre at the same time and should not be on more than one on-call rota if this results in a worse than 1:4 rota for the individual.

The CRG strongly supported ensuring that rare and complex operations were only undertaken in a smaller number of centres and by a small number of surgeons, to assure the best outcomes. Network proposals that supported this should be favoured.

The panel considered it particularly important that networks were able to ensure that rare and complex operations were only undertaken by a small number of surgeons, to assure the best outcomes.

Co-location

Co-location was not achieved in all of the proposals. The CRG felt that where appropriate mitigation was in place in the absence of co-location, services should not be halted or penalised if their mitigations were safe, monitored and did not reduce patient outcomes.

The panel however considered it particularly important that networks were able to ensure that L1 paediatric CHD services were delivered from sites achieving the required service interdependencies.

Stopping low volume interventional and surgical practice / Tackling non-specialist centres that do not meet the appropriate standards

The panel considered that the process for managing occasional practice will need to be considered more carefully by Networks and linked back to their governance. Better access to nationally available data will (noting the information governance issues) enable networks to take the appropriate action.

2.3 Network service model and service integration

The panel considered the clarity of the proposed governance arrangements to be particularly important, as was the involvement of all partners in these, including patients and their representatives.

The CRG considered that that these arrangements would be more developed during implementation, but advised that clarity was required for safe effective networked working. The best submissions were those that had worked out their approach to accountability, governance and a shared approach to resilience.

The panel considered the resilience of the arrangements described to be particularly important. The CRG advised that there needs to be a clearer understanding of how Networks will offer support to each other both regionally and nationally when there is a crisis that will affect the service; for example: infections preventing operations/procedures, surges in demand, loss of surgical staff. The proposals also need to offer sufficient resilient to cope with disruptive change, for example in treatment modalities which might significantly affect volumes of surgical and interventional activity.

Proposals require a clear demonstration of how all the centres in a network will work together and not just L1 centres.

Network working will require data and information sharing across the Network. This was mentioned in a number of the proposals; however the CRG felt it was essential in developing services and improving patient outcomes and in order to address occasional practice.

2.4 Capacity, activity& access

The CRG considered that the activity assumptions put forward by NHS England were a sound basis for planning.

While many of the submissions used the activity assumptions broadly in line with NHS England's own projections (with a number of exceptions) the combined level of surgical activity envisaged within the submissions exceeded NHS England's expectations by 410 (7.7%) by 2021/22.

This was considered to have resulted from a desire to demonstrate sufficient activity to meet the standards, and the panel did not consider this activity level to be realistic.

There were significant overlaps in population coverage across the submissions and several were dependent, for their success, on NHS England mandating changes to patient flows.

While the regulations relating to specialised commissioning mean that NHS England could make decisions about the disposition of services, including patient flows, we would prefer to work with providers to establish the appropriate models to deliver the standards, including; agreed, rather than imposed, network boundaries. It was agreed that while some change could be achieved, the scale and pace envisaged in the submissions was unrealistic.

The CRG advised that in determining network boundaries the following requirements should be considered:

- Flexibility to support patient choice.
- Recognition that at the boundaries of networks patients may be referred to more than one provider depending on where they live and travel arrangements.
- Recognition that patients with multiple pathologies may prefer to receive their all their care in one place even if not the closest.
- In general a patient should receive their whole lifetime care within one network (recognising that choosing to use a different centre for surgery did not affect this principle).
- Competitive behaviours could affect professional relationships and were seldom in the patients' interests.
- Striving to achieve better quality than other units was not considered a problem.
- Patients should not be asked to drive past one centre to another to make up the numbers.
- An agreement about network boundaries should be reached across London and the southeast.

The CRG advised that the availability of sufficient capacity is essential – the capacity of each network needs to be considered carefully along with that of interdependent services, e.g., paediatric intensive care units. Particular concerns were expressed about the capacity of the national paediatric advanced heart failure and transplant service, noting the impact that the current surge in demand was having on the centres hosting the service and their ability to take tertiary referrals.

The CRG advised that distance travelled for surgery was seen as less important than traveling continually for ongoing care.

2.5 Affordability

NHS England undertook a full financial assessment as part of its work on new standards for CHD services and concluded that the costs of providing the service to the new standards would be met from the additional funding hospitals can expect to receive from predicted rises in activity levels.

A number of proposals suggested that they were dependent on additional funding. As NHS England was clear that the service would be tariff funded, networks need a clear understanding of how the improvements highlighted within the proposals will be funded and whether these are affordable.

Providers need to work together to ensure that they understand better how to appropriately bill for outreach clinics.

2.6 Staff/workforce

The panel considered networks' understanding of the workforce challenges particularly important including their ability to recruit and retain the necessary staff, not just surgeons but also cardiologists, specialist nurses and psychologists.

Where change was proposed the impact on the national pool of scarce skills needed to be considered.

2.7 Deliverability

In addition to the factors previously described, the panel considered the deliverability of what was proposed to be particularly important.

This included:

- assessment of the risks associated with moving from the present state to the future state described
- strategic fit and contribution to a nationally coherent solution, exhibiting collaborative working
- consideration of the impact of any potential change on dependent services especially PICU and advanced heart failure/transplant

The CRG advised that all proposals put forward should be considered from the perspective of the short and long term risks to patient outcomes.

3 Commissioning response

While individual ratings varied, overall it was considered that:

- The present approach had not yielded a series of submissions that produced an acceptable solution, in the best interests of patients, and neither is it likely that this would change if the providers were given more time.

- The current commissioning approach adopted by NHS England, based on providers working together to develop proposals that meet the standards, needed to change.
- Developing a nationally coherent delivery model will require significant support and direction by NHS England acting as commissioner.

Two submissions covered an almost identical population in the North West of England, one with services centred in Liverpool, the other with services centred in Manchester. This made clear that at most only one of these proposals could proceed in the form envisaged and that a judgement would be needed on which carried the greatest patient benefit, with the lowest level of risk.

NHS England will now consider the appropriate commissioning approach that will optimise consistency in the application of standards across the provider landscape. However different commissioning approaches may be appropriate to each network's situation. As with the network proposals, deliverability will be a consideration. We will work with local clinical commissioners to address the need for an integrated approach across the three tiers of the service.

We are aware of the need to ensure that the April 2016 standards are met as soon as possible, and this will be taken into account in developing our plans. We expect to work with providers to ensure that immediate action is taken to ensure that appropriate short term mitigations are put in place in to provide assurance of safety wherever the standards are not fully met.

Appendix 1: Process for review of the submissions

Review of the submissions included four distinct components:

1. **Regional commissioner review:** to add commentary to the submissions based on local knowledge.

2. **Activity analysis:** to compare the submissions to NHS England's baseline assumptions, identify all variations and comment on them. Also to ensure that the whole population of England is covered within the submissions and that no part of the population is counted by more than one network.

3. **CRG review:** to provide clinical and service user perspectives.

4. **National commissioner panel:** to produce a qualitative assessment of the submissions, informed by the regional, analytic and CRG reviews. To agree feedback to each emerging network and to make recommendations to SCOG on the commissioning approach most suited to ensuring timely progress towards meeting the standards.

National Panel Membership

Panel Chair
Will Huxter, Programme SRO, NHS England
Patient and Public
Suzie Hutchinson, Nominated CRG PPE representative
Michael Cumper, Nominated CRG PPE representative
Clinical
Professor Deirdre Kelly, Chair, Clinician Engagement and Advisory Group
Dr Trevor Richens, Chair, Congenital Heart Services CRG
Dr Jackie Cornish, POC Board clinical representative
Commissioning
Cathy Edwards, Operational Delivery Director (National), Specialised Commissioning, NHS England
Catherine O'Connell, Regional Director Specialised Commissioning, NHS England Midlands and East
Hazel Fisher, AD Programme of Care & NW London Locality Lead, NHS England London
Dr Vaughan Lewis, Regional Clinical Director for Specialised Commissioning, NHS England South
Dr Alison Rylands, Regional Clinical Director for Specialised Commissioning, NHS England North
Julia Grace, Accountable Commissioner, NHS England
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